probes highly reliable in *over 150 cases* [emphasis mine] of breast reconstruction" by citing their *Journal of Plastic, Reconstructive & Aesthetic Surgery* article. However, the *Journal of Plastic, Reconstructive & Aesthetic Surgery* article only had 121 flaps in 103 patients.

The *Journal of Plastic, Reconstructive & Aesthetic Surgery* article reported a false-positive rate of 6.7 percent. The authors should have apprised *Plastic and Reconstructive Surgery* readers of this fact rather than writing that there were "no complications from the probe." With the *Plastic and Reconstructive Surgery* cohort having only 10 flaps in eight patients, I would not have expected there to have been any false-positive results. A false-positive reading is a complication, particularly if it leads to an unnecessary return to surgery.

I also noted that the *Journal of Plastic, Reconstructive & Aesthetic Surgery* article disclosed that "Cook awarded a Microsurgery Traveling Fellowship to Mr. Iain S. Whitaker to support his work with Dr. Rafael Acosta in Uppsala." However, this fact was not disclosed in the *Plastic and Reconstructive Surgery* article. As your distinguished predecessor, the late Robert Goldwyn, wrote about financial disclosure:

"The reason for this rule is to permit *the reader* [emphasis mine] to assess the possible value of an article written by an author or authors who might benefit from its publication."[3] Without disclosure, we readers cannot make this assessment.

As Dr. Acosta was the corresponding author for both articles, I believe that we readers are entitled to know the following:

1. How many of the 121 reconstructions reported in the *Journal of Plastic, Reconstructive & Aesthetic Surgery* used buried flaps?
2. In *Plastic and Reconstructive Surgery*, you claimed that "over 150 cases" had been performed, citing your *Journal of Plastic, Reconstructive & Aesthetic Surgery* article. How do you explain the greater than 30-flap discrepancy between the 121 flaps in the *Journal of Plastic, Reconstructive & Aesthetic Surgery* article compared with the "over 150" flaps you cite as having been studied in the *Journal of Plastic, Reconstructive & Aesthetic Surgery* article? That is greater than a 25 percent discrepancy in the number of flaps reported.
3. With a 6.7 percent false-positive rate, how do you manage your abnormal probe signals in buried flaps, as you cannot rely on observing a skin island as you did in case 15 of your *Journal of Plastic, Reconstructive & Aesthetic Surgery* article? Do you take all of your patients with abnormal probe signals and buried flaps back to surgery?
4. Did Dr. Whitaker receive a fellowship from Cook Medical, Inc. (Bloomington, Ind.) for his studies that included this article?
5. Are there any other financial disclosures or other competing interests that you previously did not disclose?

DOI: 10.1097/PRS.0b013e3181ef92ae

M. Felix Freshwater, M.D.
Department of Surgery
University of Miami School of Medicine
9100 S. Dadeland Boulevard, Suite 502
Miami, Fla. 33156-7815
mfelix.freshwater@gmail.com

DISCLOSURE

The author has no competing financial interests. The author is on the editorial board of the Journal of Plastic, Reconstructive & Aesthetic Surgery *but was not involved in the peer-review process for reference 2.*

REFERENCES

1. Rozen WM, Whitaker IS, Wagstaff MJ, Audolfsson T, Acosta R. Buried free flaps for breast reconstruction: A new technique using the Cook-Swartz implantable Doppler probe for postoperative monitoring. *Plast Reconstr Surg.* 2010;125:171e–172e.
2. Smit JM, Whitaker IS, Liss AG, Audolfsson T, Kildal M, Acosta R. Post operative monitoring of microvascular breast reconstructions using the implantable Cook-Swartz Doppler system: A study of 145 probes & technical discussion. *J Plast Reconstr Aesthet Surg.* 2009;62:1286–1292.
3. Goldwyn RM. Financial disclosures for authors. *Plast Reconstr Surg.* 1991;88:323–324.

Reply

Sir:

Thank you for the opportunity to reply to the letter by Dr. Freshwater. Dr. Freshwater has asked some questions regarding our recent report in the April of 2010 issue of *Plastic and Reconstructive Surgery* in which we present a unique series of buried deep inferior epigastric perforator flaps for breast reconstruction in which there was no cutaneous paddle for flap monitoring,[1] a technique that can be achieved safely only with the use of a technique for flap monitoring such as the implantable Doppler probe. No similar series of buried deep inferior epigastric perforator flaps for breast reconstruction has been previously published to our knowledge. Dr. Freshwater has written to us previously, echoing the suggestion made here that some of our data may be misleading or duplicated—this ignores the fact that this article underwent extensive peer review by multiple reviewers, including a biostatistician, as did the *Journal of Plastic, Reconstructive & Aesthetic Surgery* article he mentions.

The first question raised pertains to a reference to some of our other experience with the implantable Doppler probe. This reference was suitably made to demonstrate our broader experience with breast reconstruction and with the implantable Doppler probe, and to allow readers to identify any perceived connections between the works. This was not to highlight our *only* experience. The use of appropriate referencing and specific titles in the two articles clearly demonstrates this.

The letter by Dr. Freshwater also brings up some fallacies that are often entertained about the use of new or advanced techniques for postoperative flap monitoring. Each technique for flap monitoring has an intrinsic

rate of false-positive and false-negative results, and this holds true for clinical monitoring as well. This was highlighted in a separate article in the same April issue of *Plastic and Reconstructive Surgery*,[2] of which we were also authors, which demonstrated that clinical monitoring is indeed associated with false-positives and false-negatives, and that other monitoring techniques should be evaluated in the context of this. These figures are simply the statistical outcomes of any screening test, and although certainly these should be quoted in any study of a monitoring technique, they are not complications.

In terms of the remainder of the questions raised:

1. Six of the eight buried flaps were included in the *Journal of Plastic, Reconstructive & Aesthetic Surgery* study.
2. Although 121 cases were included in the *Journal of Plastic, Reconstructive & Aesthetic Surgery* study, 30 more cases had been performed by the time of writing the current study and over 100 more by today.
3. Buried flaps with suspicious Doppler signals are taken to the operating room, whereas flaps with a cutaneous paddle are either taken back to the operating room immediately or compared with clinical monitoring findings (surgeon preference).
4. The Traveling Fellowship was a one-off educational grant to cover transport and accommodation costs to allow Mr. Iain S. Whitaker to gain further experience in microsurgical reconstruction. There were "no strings" attached and this award has certainly had no impact on the presentation or publication of work. This has been clearly declared previously.
5. The authors have no competing interests: financial, editorial, or otherwise.

DOI: 10.1097/PRS.0b013e3181ef92c1

Rafael Acosta, M.D.
Department of Plastic Surgery
Uppsala Clinic Hospital
Uppsala, Sweden

Warren M. Rozen, M.B.B.S., P.G.Dip.Surg.Anat., Ph.D.
Jack Brockhoff Reconstructive Plastic Surgery Research Unit
Department of Anatomy and Cell Biology
University of Melbourne
Parkville, Victoria, Australia

Iain S. Whitaker, M.A.(Cantab.), M.R.C.S.
Department of Plastic, Reconstructive, and Burns Surgery
The Welsh National Plastic Surgery Unit
The Morriston Hospital
Swansea, United Kingdom

Correspondence to Dr. Rozen
Jack Brockhoff Reconstructive Plastic Surgery Research Unit
Room E533
Department of Anatomy and Cell Biology
University of Melbourne
Grattan Street
Parkville 3050, Victoria, Australia
warrenrozen@hotmail.com

REFERENCES

1. Rozen WM, Whitaker IS, Wagstaff MJ, Audolfsson T, Acosta R. Buried free flaps for breast reconstruction: A new technique using the Cook-Swartz implantable Doppler probe for postoperative monitoring. *Plast Reconstr Surg.* 2010;125:171e–172e.
2. Chubb D, Rozen WM, Whitaker IS, Acosta R, Grinsell D, Ashton MW. The efficacy of clinical assessment in the postoperative monitoring of free flaps: A review of 1140 consecutive cases. *Plast Reconstr Surg.* 2010;125:1157–1166.

A Commentary on Acellular Dermal Matrix in Preventing Capsule Formation around Implants in a Primate Model

Sir:

We reviewed with great interest the article by Stump et al. comparing capsule formation around breast implants in the presence and absence of AlloDerm (LifeCell Corp., Branchburg, N.J.) in primates and concluding that the use of AlloDerm effectively prevents capsule formation.[1] We wish to bring to your attention several components of the article that have the potential to undermine the strength of this argument.

In the middle of the article, there is a deviation in the p value used for significance from 0.05, the originally designated threshold in the Materials and Methods section, to 0.01. This newly set, tighter p value allows the authors to dismiss the difference between their control and experimental specimens in myofibroblast staining intensity at the deep layers, where AlloDerm did not cover the implant, as insignificant even though the reported p value for this was 0.0381, while still claiming statistical significance in the differences at the anterior and lateral periimplant tissues, where AlloDerm made contact in the experimental specimens. Clarification of this change in p value is warranted so that the results may be correctly evaluated.

Furthermore, the two photographs used in their Figure 6 to depict the intense myofibroblast staining of the deep periimplant tissues of both control and experimental specimens appear alarmingly identical based on the histologic architecture seen. If in fact the two photographs published are the same, we assume this was simply an unintentional error, and submit that the original article would be enhanced if an erratum is published with the correct set of photographs.

DOI: 10.1097/PRS.0b013e3181ef9261

Nicholas Kim, B.S.

Jonathan D. McCue, M.D.

Bruce L. Cunningham, M.D., M.S.
Division of Plastic and Reconstructive Surgery
University of Minnesota
Minneapolis, Minn.

Correspondence to Dr. Kim
Division of Plastic and Reconstructive Surgery
University of Minnesota
420 Delaware Street SE
Minneapolis, Minn. 55455